DC Healthy Families

Because some of the best things in life are free.

Call 1-888-557-1116

TDD/TTY 1-877-6-PARENT

RESPONSIBILITIES

I understand that I may be asked to provide proof of the information that I have given in this Application. My signature on this Application grants permission to verify this information. If I refuse to provide the proof or if I refuse to give my permission, I understand that my Application for DC Healthy Families (Medicaid or Medical Assistance) may be denied.

I must give complete, accurate, and truthful information. If I refuse to give needed information, my eligibility for assistance may be denied. If I knowingly give false, incorrect or incomplete information, or fail to report changes, I could lose my benefits and be prosecuted for fraud, fined and/or imprisoned.

I understand that as a condition of eligibility, I may be asked to apply for and cooperate with the Income Maintenance Administration in obtaining a social security number, alien/verification or taxpayer identification number for myself and the persons for whom I am applying for assistance. This information will be used to verify benefits, and make required program changes. Any difference between the information provided and these records will be investigated and may require a home visit. Information from these records may affect my eligibility and the persons for whom I am applying.

I understand that the Department of Human Services ("DHS") will verify some of the information that I have given by using computer-generated matching systems. My permission is not required for this. During this process, the Department will take care to protect my rights to confidentiality.

I understand that I must report any changes in my situation that might affect my eligibility and I agree to report such changes no later than 10 days after the changes occur.

I understand that my case may be chosen for a Quality Control review by the Medical Assistance Program. This is a detailed review of all of the information in the case record and may include some personal interviews. If my case is chosen, I agree to cooperate fully with the state or federal Quality Control representatives. If I do not cooperate, my Medical Assistance may be terminated.

I understand that if I am eligible for Medical Assistance I am required to use all other available resources such as my health insurance, Medicare, Blue Cross/Blue Shield, veterans' insurance, and veterans' medical facilities before I use my Medical Assistance coverage.

I understand that by signing this application I am assigning to the Department of Health ("DOH") the right to any third party payment or health insurance benefits, for all or part of my medical expenses, that have been incurred by DOH for care and treatment that has been provided or paid for as medical care assistance. Furthermore, if I institute a legal proceeding against or enter into settlement negotiations with a third party, I must provide within twenty calendar days, written notice of the action either by personal services or certified mail to the Medical Assistance Administration, Third Party Liability Section, 33 N Street, N.E., Washington, DC 20002.

I understand that by signing this application I am accepting responsibility for this application and am liable to criminal penalties if I have made any false or misleading statements. I agree to refrain from withholding information, or failing to report changes promptly. I understand that the maximum penalty for Medicaid fraud is a fine of $1,000 and a jail sentence of three years.

RIGHTS

I understand that under federal law, an eligibility determination for receipt of medical benefits will be made within 45 days.

I understand that if I am a DC Healthy Families (Medicaid) recipient and give birth, my baby will receive medical benefits for one year, as long as the infant continues to live with me, and we are residents of the District of Columbia.

I understand that if I believe I have been discriminated against because of my race, color, national origin, mental or physical handicap, or any other reason, I may file a complaint within 180 days to the D.C. Department of Human Services.

I understand that if I am dissatisfied with any action or lack of action by the Department of Human Services ("DHS") and/or the Department of Health ("DOH"), I may ask for a fair hearing by calling the Office of Fair Hearings at (202) 724-5432.

I understand that if I have been on Medical Assistance any time since March 20, 1990, I may be entitled to repayment for any money spent for drug prescriptions, doctor visits or hospitalizations. For more information, I can call the Medicaid Recipient Claims Research Team of the Medical Assistance Administration at (202) 727-0725 or Terris, Pravlik & Wagner, 1121 12th Street, N.W., Washington, DC 20005 at (202) 682-0578.

EPSDT/WELL-CHILD PROGRAM

The Well-Child Program provides free check-ups and treatment to Medicaid eligible and/or DC Healthy Families eligible children under age 21. The Well-Child Program is very important and can be obtained from any doctor or clinic participating in the Medicaid program. The Well-Child Program also helps in scheduling appointments and providing transportation to the doctor's office. For help in scheduling appointments and providing transportation, call 1-800-666-2229. For more information about the program, call (202) 727-0725.

PLEASE DETACH AND KEEP THIS PAGE. MAIL THE COMPLETED AND SIGNED APPLICATION, TOGETHER WITH PROOF OF YOUR INCOME, DEPENDENT CARE EXPENSES AND THAT YOU LIVE IN THE DISTRICT OF COLUMBIA, TO:

DC Healthy Families
ATTN: DC Healthy Families Unit
645 H Street, N.E
Washington, DC 20002

INSTRUCTIONS FOR COMPLETING THE DC HEALTHY FAMILIES APPLICATION

MAKE SURE YOU READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE APPLICATION

GENERAL INFORMATION

If you are an adult in a family with one or more children under the age of 19, you may use this Application to **apply** for:

➤ **DC Healthy Families (Medicaid or Medical Assistance)**

WHO SHOULD NOT COMPLETE APPLICATION

If you fall under any of the following categories, you should not use this "Short Form" Application to apply for Medical Assistance, but rather a regular Medicaid Application.

➤ Childless adults
➤ Aged and disabled individuals
➤ Medicare beneficiaries

COMPLETING THIS APPLICATION

If you need help completing this Application, a friend, relative or other individual may help you, or you can call 1-888-557-1116. If you are completing this Application for someone else, answer each question as if you were that person. If you need to change your answer, write the correct information nearby and put your initials and the date next to the change. If you are applying for DC Healthy Families, are under 21 years of age and live with your parent or legal guardian, they must sign the Application on your behalf.

REQUIRED SUPPORTING DOCUMENTATION

This Application **must** be accompanied by the following supporting documentation for **each** person for whom you are applying. (Attach **copies only.**)

Proof of residence in the District of Columbia (such as, a copy of your income tax return or Earned Income Credit form, a utility or telephone bill with your address, copy of a lease, a rent receipt, a valid District of Columbia drivers license, or a voter registration card).
Proof of earned income for one month prior to the date of application. For example, if you are paid:

➤ weekly you will need your **four** most recent pay stubs
➤ bi-weekly you will need your **two** most recent pay stubs
➤ monthly you will need your most recent pay stub

Proof of Social Security Number (SSN) or proof that the SSN has been applied for. For example, a copy of:

➤ Social Security Card
➤ Social Security Benefits documents showing SSN
➤ Other federal or state benefits statement showing SSN
➤ Application for SSN (SS-5)

Proof of dependent care expense for one month (such as a canceled check, bill, statement or receipt from the provider showing who received the care, cost of care and the period during which care was provided).

GENERAL INSTRUCTIONS

The following instructions will assist you with completing this Application.

1. Please print all answers. Illegible responses will cause delay in processing your application.
2. If you are deaf, have access to TDD/TTY, and need help with completing this application call 1-877-6PARENT
3. Attach additional sheets of paper if you need more space to complete any section of this Application.
4. Be sure to carefully read the section entitled *YOUR RESPONSIBILITIES AND RIGHTS* and sign the Application.

STEP-BY-STEP INSTRUCTIONS

PART I: APPLICATION FOR HEALTH INSURANCE

Question #1: If you are a parent, guardian, or grandparent you can apply for benefits on behalf of a child who is in your custody. If you are a parent, **legal** guardian, or grandparent you can apply for benefits on behalf of yourself.
Question #2: A **family unit** is defined as parent(s), spouses and/or legal guardian/s and their dependents who live with them and for whom they provide financial support. All members of the family unit count toward family size even if all family members are not applying for benefits. You do not need to provide the social security number for any persons whom you are not applying for benefits.
Please enter one of the codes below in the column titled "race":
Code 1: White (Non-Hispanic Origin)
Code 2: Black (Non-Hispanic Origin)
Code 3: Asian -Pacific Islander
Code 4: American Indian or Alaskan Native
Code 5: Hispanic
Question #3: Gross income refers to the amount of income you make from employment before taxes are taken out. If you are self-employed and do not have a tax identification number, please provide a letter from individuals and/or companies for whom you work. You must also provide their address and phone number.
Question #4: Please provide information about income from all sources other than employment.
Question #5: Please provide information on monthly out-of-pocket dependent care expenses that you pay in order for you or anyone in your family unit to work. Please also provide me requested information about the care provider and proof of one month's expenses. (Providing this information may help your family qualify.)
Question #6: Retroactive coverage means that the program will pay your outstanding medical bills for up to three months prior to the date of application for insurance benefits under me DC Healthy Families program.
Question #7: Please provide this information for every child for whom you are applying who has an absent or deceased parent. If you don't provide this information, it will not affect your child's eligibility; however, it may affect a parent's eligibility unless he/she has a good reason for not providing it. An example of a good reason is fear of physical, sexual or emotional harm to you or your children.
Question #8: Please provide this information about anyone for whom you are applying who has health insurance coverage. (Having health insurance does not prevent you from receiving DC Healthy
Question #9: Please provide this information for anyone for whom you are applying for coverage.
Question#10: This question is asked solely for research purposes. Your answer to this question will have no bearing on your eligibility determination.

PART 2: QUESTIONS FOR IMMIGRANTS

If you answered NO to Question 9 on Part I of this Application, you must complete Part 2.
All requested information must be provided, including alien number (if applicable). It is not necessary to attach supporting documentation, but the information provided on the form will be verified. All information regarding immigration status will be kept confidential.

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PART 1: APPLICATION FOR HEALTH INSURANCE

YOU MUST READ ATTACHED INSTRUCITONS BEFORE COMPLETING THIS APPLICATION

This Application is a statement *of facts about you and the people in your family who need health insurance. You must answer all questions before we will know if we can help you. If you need help completing this form, please call 1 888-557-1116. Please print.*

I received help filling out this application from: ⦿ Hotline Staff ○ Community Worker ○ I Did It Myself ○ Other (identify) _____

Were you satisfied with the help you received? ○ Yes ○ No

1. Parent or caretaker filling out this Application

Last Name	First Name		Middle	
Address Where You Live	Street	City	State	ZIP
Mailing Address (if different)	Street	City	State	ZIP
Home Phone	Work Phone	Phone for Messages		

2. List all the members of your family unit. (See #2 on the instruction page.)

Name (Last, First, Middle)	Date of Birth	Sex (M/F)	Race (Code) (Optional)	Pregnant (Y/N)	Relationship to You	Relationship to Your Spouse	Applying for Benefits (Y/N)	Social Security Number (**only** for those for whom you want benefits) If the person for whom you want benefits does not have a Social Security Number place an X in the box

3. List all pretax Income received from employment for yourself and other adult members of your family unit (including self-employment).

Your Gross Income	Parent or Other Adult Family Member's Gross Income
Amount earned: $_____ ☐ No Income **(circle one)** ○ Hourly ○ Weekly ○ Bi-Weekly ○ Monthly ○ Yearly Hours worked each week:_____	Amount earned: $_____ ☐ No Income **(circle one)** ○ Hourly ○ Weekly ○ Bi-Weekly ○ Monthly ○ Yearly Hours worked each week:_____
Employer Name and Phone Number:	Employer Name and Phone Number:
If self employed, check here and provide your tax identification number. TAX ID #_____ Self-Employed ☐ **If you do not have a tax identification number, write a statement describing your employment and income and include it with your application.**	If self employed, check here and provide your tax identification number. TAX ID #_____ Self-Employed ☐ **If you do not have a tax identification number, write a statement describing your employment and income and include it with your application.**

4. List all other income received by members of your family unit (Including income for yourself, your spouse and your children).

Source of income	Who Receives This Income?	Amount of Income	How Often is the Income Received?
Child Support			
Alimony			
Social Security Benefits			
SSI			
Worker's Compensation			
Other (please explain)			

5. If you or someone in your family unit pays for dependent care (child care or for care of an adult who lives with you who cannot care for himself) in order to work, please give us the following information. (Providing this information may help your family qualify.)

Name of Person Who Works	Person(s) Cared For	Monthly Amount Paid?	Name of Dependent Care Provider	Telephone Number of Dependent Care Provider

(circle one)

6. Does anyone for whom you are applying have any paid or unpaid Medical bills (e.g. hospital bills, doctor bills and prescription drugs) from the past 3 months? If YES, we may be able to help you pay these bills. Contact the DC Healthy Families Unit at 202-698-4200. **○ YES ○ NO**

7. Please provide information about an absent or deceased parent of a child for whom you are applying for benefits. If you don't provide this information, it will not affect your child's eligibility; however, it may affect a parent's eligibility unless he/she has a good reason for not providing it. (See #7 on the instruction page for an example of a good reason. If you feel that you have a good reason, check here. ☐

Child's Name (Last, First, Middle)	Absent or Deceased Parent's Name	Absent (A) or Deceased (D)?	Parent's SSN	Last Known Address	Sex (M/F)	Date of Death

8. Does anyone for whom you are applying for benefits currently have other health Insurance? YES ○ NO ○
If YES, please provide the following information: (Having health insurance does not prevent you from receiving DC Healthy Families.)

Health Insurance	Name of Policyholder	Name and Address of Insurance Company	Group Number	Policy/Cert/SSN

9. Is everyone for whom you are applying a U.S. citizen? **YES ○ NO ○**
If you answered "NO" you MUST complete Part 2 of this application.

10. Has health Insurance been dropped in the last three months for any child for whom you are applying? YES ○ NO ○ Any parent? YES ○ NO ○
If you answered "YES," was coverage from Kaiser Kids? **YES ○ NO ○**

By my signature below, I certify under penalty of perjury that the information I have provided in this Application is true, complete, and correct to the best of my knowledge and belief. I have read and understand the Rights and Responsibilities and the Medicaid Well-Child Program information printed on Page 3 of this Application.

Signature of Applicant_____ **Date:**_____
(LEGAL SIGNATURE OR "X" MARK)

Signature of Witness to an "X" Mark_____ **Date:**_____
(A witness is required only if the Applicant makes an "X" mark instead of signing his or her name.)

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Application for Health Insurance

PART 2: APPLICATION FOR HEALTH INSURANCE

YOU MUST READ ATTACHED INSTRUCITONS BEFORE COMPLETING THIS APPLICATION

The information that you give us will be kept confidential as required by state and federal law.

Leave this page blank if you answered YES to question 9 on Part 1 of this Application.
Fill out this page if you answered NO to question 9 ort Part 1 of this Application.

Immigration Status: Complete the chart below for each family member who is not a U.S. citizen and who is applying for benefits. Your identification with one or more immigration status codes is neither a guarantee of eligibility or indication that you will be denied insurance benefits. For certain status codes you may be contacted by the Income Maintenance Administration to provide more information. List all statuses that have applied to each person since the person entered the U.S.

Use the numbers below to describe your status:

1. Legal permanent
2. Refugee
3. Asylee
4. Cuban/Haitian Entrant
5. Person who has had his/or her deportation (removal) withheld
6. Parolee admitted for at least one year
7. Alien who has been present since before April 1, 1980, as “conditional entrants"
8. A person on active duty or a veteran of the U.S. Armed Forces with an honorable discharge
9. Spouse, widow or dependent of someone on active duty or a veteran of the U.S. Armed Forces with an honorable discharge
10. A victim of domestic violence, or a child of such a victim, who is no longer living with the abuser
11. Legal permanent resident who was present in the U.S. before August 22, 1996
12. Other (check here) ☐

Complete the following information ONLY for persons for whom you are applying for benefits and who are not citizens of the U.S. (attach extra page if necessary). If you checked status #12 (Other) write #12 in the Status Number(s) box.

Name (Last, First, Middle)	Status Number(s) (List all that apply)	Date Status Awarded	Alien #	Verification # OFFICE USE ONLY	U.S. Entry Date